Interviewer's initials_____ Date of Interview (Open date)_____

Personal Injury Intake

Date of Accident_____ Referred By: _____

Address & Phone of
Referrer_____

Occupation of Referrer_____ Relationship to client_____

Client
Name(s)_____

Address_____

Home phone_____ Work phone_____

Third Phone # and name_____

DOB_____SSN_____

Spouse (or parent/guardian/admin/exec's) name_____

Relationship: husband/wife/mother/father/guardian/admin/exec)_____

Date & Place of marriage_____

Address same?_____ Spouse's DOB_____ Spouse's SSN_____

Representative's address & phone, if different_____

If injured party deceased, who had expectation of support?
(H/W/son/daughter/father/mother)_____

Client Employer (or
School)_____

Employer (or School)
Address_____

Employer (or School)
Phone_____ _____

Type of work (or
degree)_____

Length of time at this job (or school)(Include start date)_____

Time lost from work (or classes) so far (indicate if school break)

_____

Was client in course of employment at time of accident?_____

Salary: _____

DATE OF ACCIDENT:_____ TIME OF ACCIDENT _____
WEATHER_____

LOCATION_____

# of vehicles involved _____

Street on which Plaintiff driving_____

Direction(compass)_____

One way street?_____ No. of lanes of moving traffic_____

Parkinglanes_____

Road surface (Level/grade/defects/construction)_____Light/dark

out_____

FACTS IN DETAIL (Include starting point and intended destination, e.g. home/store):

_____
_____
_____
_____
_____
_____
_____
_____

Client Vehicle (year, make, color)

_____

Client auto insurer & Policy #: _____

_____

Policy Limits(25/50, 100/300, 300/500 etc)_____

UM COVERAGE? _____ If so, Policy Amounts: _____

Property Damage_____

_____

What portion of defendant's vehicle struck which portion of plaintiff's vehicle? _____

_____

_____

_____

_____

Collision Insurance? _____

Could car be driven after accident? Who moved/drove it?_____

_____

Where was car taken or towed after accident? _____

Is Client
Owner/Operator//Passenger/Pedestrian?_____

Other household car?_____ Name of owner & relationship_____

_____

Other household car Carrier & Policy #_____

Policy Limits_____

1st Offending vehicle (Yr, make, color)_____

Owner name, address_____

Driver name, address_____

1st Defendant Carrier & Policy #_____
Policy Limits_____

2nd Offending vehicle (Yr, make, color)_____
Owner name, address_____

_____

Driver name, address_____

_____

2nd Defendant Carrier & Policy #_____
Policy Limits_____

Did police come to the scene?_____ Did police witness accident?_____
Photos taken?_____ Who has photos?_____

Witness #1 name & phone_____
Witness address_____

Witness #2 name & phone_____
Witness address_____

Ambulance? _____ Hospital_____

ER/admitted & dates_____

Doctors_____

Injuries_____

Other health insurance (Include Medicare, Medicaid – office & #s)_____

Other income (Include welfare, SSI, disability, worker's comp)_____

Other counsel (Include worker's comp)_____

Prior actions (Date & injuries) (Include actions v. city)_____

Prior counsel, Name & Address_____

Resolution (Settlement/Verdict)_____

INJURED CLIENT INTAKE FORM

NAME: _____ DATE: _____

Major area of complaint: _____

P = Local pain. N = Numbness. R = Radiating Pain. Y = Yes.

A. HEAD AREA:

1. _____ Front of head.
2. _____ Back of head.
3. _____ Top of head.
4. _____ Headaches.
5. _____ Blurred Vision.
6. _____ Jaw Pain and Clicking.
7. _____ Problems with your vision, smell, hearing or taste.
8. _____ Memory loss.
9. _____ Confusion.
10. _____ Dizziness, nausea or vomiting.
11. _____ Depression.

B. NECK AND UPPER EXTREMITY:

1. _____ Back of neck.
2. _____ Side of neck.
3. _____ Front of neck.
4. _____ Do you have restricted movement in the neck?
5. _____ Do you have swelling in the neck?
6. _____ Shoulder.
7. _____ Elbow.
8. _____ Wrist.
9. _____ Arms.
10. _____ Hands.
11. _____ Fingers.
12. _____ Do you have restricted movement in the arms? _____
    Do you have restricted movement in the hands? _____
    Do you have restricted movement in the fingers? _____

C. MID-BACK AND CHEST:

1. _____ Upper Back.
2. _____ Mid Back.
3. _____ Side of the ribs.
4. _____ Do you have restricted movement in the upper back? _____
    Do you have restricted movement in the mid back? _____
5. _____ Do you have swelling in the upper back? _____
    Do you have swelling in the mid back? _____

6. _____ Do you have pain radiating around to the front of the chest?
7. _____ Do you have pain shooting from the back through the chest to the front?
8. _____ Do you have difficulty breathing or shortness of breath?
9. _____ Do you have palpitations of the heart?
10. _____ Do you have increased blood pressure?

D. BACK AND LOWER EXTREMITY:

1. _____ Low Back.
2. _____ Side of the back.
3. _____ Do you have restricted movement in the back?
4. _____ Do you have swelling in the back?
5. _____ Hip.
6. _____ Groin.
7. _____ Knee.
8. _____ Ankle.
9. _____ Foot.
10. _____ Toes.
11. _____ Do you have restricted movement in the legs? _____
    Do you have restricted movement in the feet? _____
    Do you have restricted movement in the toes? _____

Additional Notes: _____
_____
_____
_____

Diagram of location & accident:

REQUEST FOR ACCIDENT RECORD

SUBMIT IN DUPLICATE

POLICE DEPARTMENT
County of Nassau
Mineola, New York

INSTRUCTIONS: SEARCH AND SERVICE FEE OF $10 AND A STAMPED, SELF-ADDRESSED ENVELOPE MUST ACCOMPANY THIS REQUEST. MAIL TO POLICE DEPARTMENT, COUNTY OF NASSAU, RECORD AND LICENSE BUREAU, 1490 FRANKLIN AVENUE, MINEOLA, N.Y. 11501.

Record and License Bureau File No. _____

Accident/Aided No. _____

PRINT OR TYPE

TO THE POLICE DEPARTMENT:

(Fill in Nos. 1 to 6 inclusive.)

1. Date of accident _____ Location _____

3. Operators of vehicles, if known _____

4. Name(s) of injured _____

5. Patrolman's name, shield # and precinct, IF KNOWN _____

6. Applicant must be one of the following: (Check item below best describing your interest in case.)

____ Person injured in accident.

____ Parent or guardian of injured (in case of minor)

____ Executor or administrator of the estate of next of kin (in case of death)

____ Husband or wife

____ Insurance beneficiary

____ Insurer

____ Dependent in Workmen's Compensation Claim

____ Person who may become a party in an action arising out of the accident.

I, _____, _____
(Name of Applicant) (Address)

request that the above indicated record of the Police Department, relating to the accident described below, be made available for inspection to the undersigned, or to:

_____ _____
(Name of Attorney or Agent) (Address)

_____
(Applicant's Signature)

STATE OF NEW YORK, COUNTY OF NASSAU) ss.:

Sworn to before me this
day of , 2003

_____

NOTARY *STAMP*

(NOTARIZE ORIGINAL REQUEST ONLY)

RETAINER AGREEMENT

_____, (hereinafter "Client(s)", retains the Law Offices of **Lawrence M. Gordon, Attorney At Law, P.C.** (hereinafter "Attorney") to represent Client(s) as legal counsel for all purposes in connection with injuries and damages arising out of an incident which occurred on the ____th day of _____, 20__, in the County of _____, State of _____, through the negligence of _____ on the following conditions:

1. Attorney(s) will devote their full professional abilities to the case and Client agrees to fully cooperate with attorneys.

2. In consideration of the services rendered and to be rendered, Client(s) agree to pay and Attorneys agree to accept and to retain out of any monies that may come into their possession by reason of the above claim 33.3 percent of all sums recovered.

Fees shall be computed on the net sum collected after deduction of costs and disbursements. No deductions in computing fees will be made for the following: Liens, assignments or claims in favor of health care providers, self insurers or insurance carriers.

It is specifically understood that negotiation of any lien and/or payback on behalf of the Client(s) with any health insurance entity, including, but not limited to, Medicare, shall be billed to the Client(s) at $350.00 per hour, which will be deductible from the Client(s) net proceeds of any recovery herein.

3. In the event of no recovery, Client(s) shall not be obligated to pay any attorneys fees for services rendered.

4. Although Attorneys may advance costs and disbursements on the account of the client, **the client is responsible for such disbursements regardless of the outcome of the case.*** Attorneys may not ethically pay the cost of litigation without recourse to the Client(s). Said costs may include some or all of the following: Investigation, selection and retention of experts, court costs, process service, recording service, auto/travel, requisition fees, postage, copying, photos, research (Lexis), etc. ***including expert fees.**

5. **Client(s) agree that attorneys have made no promises or guarantees regarding the outcome to the Client's(s') claim** and, if after so investigating, claim does not appear to them to have merit, or in the event that it appears defendants have no insurance coverage, the Attorneys shall have the right to cancel this agreement.

6. **Appeals** - Attorneys are not obligated to take Appeals from adverse decisions or verdicts. Attorneys agree to assist Client(s) in locating and retaining appellate counsel. Fees charged by appellate counsel shall be paid by Client(s) and in the event appellate counsel agrees to a contingent fee or to defer collection of fees, these appellate counsel fees shall be treated as liens and not expenses. [We have the right to handle or refer appeals to other counsel. Our appeals rate is $450.00 per hour plus expenses.]

Dated:_____ _____L.S.

Witness:_____ _____L.S.

SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF

----------X

COLLATERAL SOURCE AUTHORIZATION

Index No.:

Plaintiff(s),

-against-

Defendant(s).

----------X

TO:

YOU ARE HEREBY AUTHORIZED to furnish to

_____, attorneys for the Defendant, a copy of the insurance records of _____, who was your insured at the time of his/her accident on _____. You are not authorized to speak to the attorneys for the Defendant or their representatives with regard to these records. You are directed to send a copy of whatever you provide to the attorneys for the Defendant to my own attorney, **Lawrence M. Gordon, Attorney At Law, P.C., 300 Garden City Plaza, Suite 450, Garden City, NY 11530.**

Dated: Garden City, New York

_____

Lawrence M. Gordon, Attorney At Law, P.C.
Attorneys for Plaintiff
300 Garden City Plaza, Suite 450
Garden City, NY 11530
(516) 333-5000

STATE OF NEW YORK, COUNTY OF NASSAU ss.:

On the day of , 20 , before me personally came and appeared _____,to me known and known to me to be the individual described in and who executed the foregoing instrument, and who duly acknowledged to me that he/she executed the same.

_____
Notary Public

SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF

----------X

EMPLOYMENT AUTHORIZATION

Index No.:

Plaintiff(s),

-against-

Defendant(s).

----------X

TO:

YOU ARE HEREBY AUTHORIZED to furnish to

_____, attorneys for the Defendant, a copy of the employment records of _____, who was employed by you at the time of his/her accident on _____. Please include in your records the exact dates of employment, rates of pay, including the days absent from work from the years _____ to the present time. You are not authorized to speak to the attorneys for the Defendant or their representatives with regard to these records. You are directed to send a copy of whatever you provide to the attorneys for the Defendant to my own attorney, **Lawrence M. Gordon, Attorney At Law, P.C., 300 Garden City Plaza, Suite 450, Garden City, NY 11530.**

Dated: Garden City, New York

_____

Lawrence M. Gordon, Attorney At Law, P.C.
Attorneys for Plaintiff
300 Garden City Plaza, Suite 450
Garden City, NY 11530
(516) 333-5000

STATE OF NEW YORK, COUNTY OF NASSAU, ss.:

On the day of , 20 , before me personally came and appeared _____,to me known and known to me to be the individual described in and who executed the foregoing instrument, and who duly acknowledged to me that he/she executed the same.

_____
Notary Public

SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF
----------X

Plaintiff(s),

NO FAULT FILE
RECORD AUTHORIZATION

- against -

Defendant(s).
----------X

TO:

YOU ARE HEREBY AUTHORIZED to furnish to

of

attorneys for the above Defendant(s), a copy of the entire no-fault record, in duplicate, of

. You are directed to send a copy of whatever you provide to the attorneys for the Defendant to my own attorney, Lawrence M. Gordon, Attorney at Law, P.C., 300 Garden City Plaza, Suite 450, Garden City, NY 11530.

Dated: Garden City, New York

Lawrence M. Gordon, Attorney At Law, P.C.
Attorneys for Plaintiff(s)
300 Garden City Plaza, Suite 450
Garden City, NY 11530

STATE OF NEW YORK, COUNTY OF ss.:

On the day of , 20 , before me personally came and appeared , to me known and known to me to be the individual described in and who executed the foregoing instrument, and who duly acknowledged to me that he executed the same.

Notary Public

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient's Name:_____ Date of Birth:_____

Patient's Address and Telephone Number:_____

Patient's Social Security Number:_____

A. I, the undersigned, hereby authorize _____ to release its medical records/medical information, or the following portions of its medical records/medical information, of the above-named patient, with respect to treatment rendered at:

___ In-Patient/Ambulatory Surgery ___ Emergency Department

___ Out-patient Department/Physician Office (please specify department or location) _____

B. Information to be disclosed (please specify):

___ Complete Health Record(s) ___ X-Ray Reports ___ History and Physical Examination
___ Discharge Summary ___ Progress Notes ___ Psychiatric Assessments/Evaluation
___ Laboratory Tests ___ Consultation reports ___ Psychotherapy Notes[1]
___ Billing Records ___ Photographs, Videos ___ Psychosocial History
___ Other (please specifiy):_____

C. Regarding treatment on (date(s) of treatment):_____

D. The records/information are to be disclosed for the purpose of _____

To the following:_____

E. Special Authorizations

IF THE REQUESTED RECORD RELATES TO PSYCHIATRIC TREATMENT OR DRUG AND/OR ALCOHOL TREATMENT, OR CONTAINS HIV-RELATED INFORMATION, YOU MUST SPECIFICALLY INDICATE YOUR CONSENT TO THE RELEASE OF SUCH INFORMATION BY INITIALING THE FOLLOWING PARAGRAPHS:

1. <u>Psychiatric Records</u> (A Separate Authorization is required for Psychotherapy Notes)

_____ (Patient/Legal Guardian's Initials)

I understand that if my records pertain to psychiatric treatment, such information will be released pursuant to this authorization form.

<u>Notice</u>. New York State Law prohibits a recipient from redisclosing mental health information without the subject's authorization unless permitted to do so under Federal or State law.

2. <u>Substance Abuse (Drug and Alcohol) Treatment Records</u>

[1] An authorization for a use or disclosure of psychotherapy notes may not be combined with an authorization for a use or disclosure of any other type(s) of information (a separate authorization is also required for human subject research purposes). *Psychotherapy notes* are notes recorded by a mental health professional documenting or analyzing the contents of conversation during a counseling session and that are maintained separate from the individual's medical record. A mental health professional has the discretion not to release psychotherapy notes.

_____ (Patient/Legal Guardian's Initials)

I understand that if my records pertain to my participation in a substance abuse treatment program, as defined in 42 CFR Part 2 of the Federal Regulations, or contain information about my treatment at the Hospital for drug or alcohol abuse, such information will be released pursuant to this authorization form.

Notice. Federal law requires that recipients be provided with the following statement:

"This information has been disclosed to you from records whose confidentiality is protected by Federal law. Federal regulations (42 CFR Part 2) prohibits you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose."

3. HIV-Related Information

_____ (Patient/Legal Guardian's Initials)

I understand that if my records contain confidential HIV-related information, such information will be released pursuant to this authorization form. Confidential HIV-related information includes information indicating that a person had an HIV-related test, or has an HIV-related infection, or HIV-related illness, or AIDS, or any information which identifies or reasonably could identify an individual as having one or more of such conditions, including information pertaining to such individual's contacts.

Under New York State Law, with limited exceptions, confidential HIV-related information can only be given to persons you permit to obtain such information by signing an authorization. I understand that I have a right to request a list of people who may receive or use my HIV-related information without authorization. I know I do not have to allow release of HIV-related information except where otherwise provided by law, and that I can change my mind about releasing information at any time before such information is disclosed. If I experience discrimination because of release of confidential HIV-related information, I can call the New York State Division of Human Rights at (212) 870-8624 or the New York City Commission on Human Rights at (212) 566-5493.

Notice. New York State Law requires that recipients be provided with the following statement:

"This information has been disclosed to you from confidential records which are protected by State law. State law prohibits you from making any further disclosure of this information without the specific written consent of the person to whom it pertains, or as otherwise permitted by law. Any unauthorized further disclosure in violation of State law may result in a fine or jail sentence or both. A general authorization for the release of medical or other information is NOT sufficient authorization for further disclosure."

F. Expiration

This Authorization is effective until (check date or event):

__ Ninety (90) days ___ One year ___Other _____

G. Disclosure/Redisclosure

By signing this authorization form, you authorize the use or disclosure of your protected health information as described above. This information may be re-disclosed if the recipient(s) described on this form is not required by law to protect the privacy of the information.

H. Refusal to Sign the Authorization

You have a right to refuse to sign this authorization. Your health care, the payment for your health care, and your health care benefits will not be affected if you do not sign this form. However, we may not be able to provide access to or release your health information unless you sign this form.

I. Revocation

If you sign this authorization, you will have the right to revoke it at any time, except to the extent that the hospital has already taken action based upon your authorization. To revoke this authorization, please write to the Director of Medical Records of the above facility.
Revised 11/04, 2/06

J. Signature

By signing below, I acknowledge that I have read and accept all of the above.

_____
Signature of Patient or Personal Representative

_____
Date

_____
Print Name of Patient or Personal Representative (parent, guardian or individual authorized to consent to the use or disclosure of information)

_____
Relationship to Patient

K. Contact Information

Below is the contact information of the personal representative, if applicable, who signed this form.

Address: _____

_____

Telephone: (Daytime) _____

(Evening) _____

THE PATIENT OR HIS OR HER PERSONAL REPRESENTATIVE MUST BE PROVIDED WITH A COPY OF THIS FORM AFTER IT HAS BEEN SIGNED. IF MAILING IN THE FORM, PLEASE RETAIN A COPY.

Revised 11/04, 2/06

Authorization for Use and disclosure of Protected Health Information Requested by the Provider for Disclosure by Other Providers or Payors[1]

1. **Patient Authorization**

I, _____, give my authorization to

_____

to disclose to the provider named below, to use or disclose my protected health information for the following described purposes:

Personal injury action _____

2. **Description of the Used or Disclosed Protected Health Information**

The protected health information that the provider will use or disclose includes the complete medical chart, including but not limited to my name, address, telephone number, social security number, insurers, payers, prior medical history, current medical status, diagnoses, operative procedures, course of treatment, and all documentation and test results created thereby.

3. **Persons Authorized to Make the Disclosure**

Any employee of the provider is authorized to disclose the protected health information.

4. **Person to whom disclosure May be Made**

Provider may disclose the protected health information to:

Name Lawrence M. Gordon, Attoney At Law, P.C.

Address 300 Garden City Plaza, Suite 450, Garden City, Ny 11530

Fax #:_____

Please indicate one: Mail Records __X__ Fax Records_____

5. **Expiration of Authorization**

This authorization shall continue until (please indicate date) _____

[1]Note to the provider: Use this authorization form whenever the disclosure is from a third party provider or the use is for a third party provider. For example, use this form when a second provider is reluctant to disclose medical records to you or a medical plan is requesting patient information.

6. Patient's Right to Revoke Authorization

I may revoke this authorization at any time by writing a letter to the provider stating my authorization is revoked. The letter must be addressed to "Privacy Officer" at the provider's current address. However, if the provider has relied on my authorization and has taken action on my protected health information, my revocation shall not be effective.

7. Redisclosure by Recipient

I understand that once the provider discloses the protected health information to a recipient, the recipient may redisclose the information, which may no longer be protected by federal or state law.

8. Conditioning of Treatment

The provider will not condition treatment, payment, enrollment in a health plan or eligibility for benefits (if applicable) on whether I provide authorization for the requested use, or disclosure.

9. Patient's Rights

I have the right to refuse to sign this authorization.

10. Acknowledgment of Reading and Agreement

By affixing my signature below, I agree that I have read and understand this authorization. If this authorization is signed by a representative of the patient, the representative's authority to act on behalf of the patient is as follows:

_____
Patient's Signature

_____
Print Patient's Name

_____
Date

_____
Personal Representative Signature (*if applicable*)

_____
Print Personal Representative's Name (*if applicable*)

Sworn to before me this _____
day of _____, 20__.

_____
Notary Public

Authorization for Use and disclosure of Protected Health Information Requested by the Provider for Disclosure by Other Providers or Payors[1]

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Personal injury action

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4. **Person to whom disclosure May be Made**

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Please indicate one: Mail Records X Fax Records_____

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_____
Patient's Signature

_____
Print Patient's Name

_____
Date

_____
Personal Representative Signature (*if applicable*)

_____
Print Personal Representative's Name (*if applicable*)

Sworn to before me this _____
day of _____, 20__.

_____
Notary Public

Authorization for Use and disclosure of Protected Health Information Requested by the Provider for Disclosure by Other Providers or Payors[1]

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3. **Persons Authorized to Make the Disclosure**

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4. **Person to whom disclosure May be Made**

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Name Lawrence M. Gordon, Attoney At Law, P.C. ___

Address 300 Garden City Plaza, Suite 450, Garden City, Ny 11530

Fax #:_____

Please indicate one: Mail Records __X__ Fax Records_____

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_____
Patient's Signature

_____
Print Patient's Name

_____
Date

_____
Personal Representative Signature (*if applicable*)

_____
Print Personal Representative's Name (*if applicable*)

Sworn to before me this _____
day of _____, 20__.

_____
Notary Public

Authorization for Use and disclosure of Protected Health Information Requested by the Provider for Disclosure by Other Providers or Payors[1]

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Personal injury action

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The provider will not condition treatment, payment, enrollment in a health plan or eligibility for benefits (if applicable) on whether I provide authorization for the requested use, or disclosure.

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_____
Patient's Signature

_____
Print Patient's Name

_____
Date

_____
Personal Representative Signature (*if applicable*)

_____
Print Personal Representative's Name (*if applicable*)

Sworn to before me this _____
day of _____, 20__.

_____
Notary Public

Authorization for Use and disclosure of Protected Health Information Requested by the Provider for Disclosure by Other Providers or Payors[1]

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I, _____, give my authorization to

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to disclose to the provider named below, to use or disclose my protected health information for the following described purposes:

Personal injury action

2. **Description of the Used or Disclosed Protected Health Information**

The protected health information that the provider will use or disclose includes the complete medical chart, including but not limited to my name, address, telephone number, social security number, insurers, payers, prior medical history, current medical status, diagnoses, operative procedures, course of treatment, and all documentation and test results created thereby.

3. **Persons Authorized to Make the Disclosure**

Any employee of the provider is authorized to disclose the protected health information.

4. **Person to whom disclosure May be Made**

Provider may disclose the protected health information to:

Name Lawrence M. Gordon, Attoney At Law, P.C.

Address 300 Garden City Plaza, Suite 450, Garden City, Ny 11530

Fax #:_____

Please indicate one: Mail Records __X__ Fax Records_____

5. **Expiration of Authorization**

This authorization shall continue until (please indicate date) _____

[1]Note to the provider: Use this authorization form whenever the disclosure is from a third party provider or the use is for a third party provider. For example, use this form when a second provider is reluctant to disclose medical records to you or a medical plan is requesting patient information.

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7. **Redisclosure by Recipient**

I understand that once the provider discloses the protected health information to a recipient, the recipient may redisclose the information, which may no longer be protected by federal or state law.

8. **Conditioning of Treatment**

The provider will not condition treatment, payment, enrollment in a health plan or eligibility for benefits (if applicable) on whether I provide authorization for the requested use, or disclosure.

9. **Patient's Rights**

I have the right to refuse to sign this authorization.

10. **Acknowledgment of Reading and Agreement**

By affixing my signature below, I agree that I have read and understand this authorization. If this authorization is signed by a representative of the patient, the representative's authority to act on behalf of the patient is as follows:

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Patient's Signature

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Print Patient's Name

_____
Date

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Personal Representative Signature (*if applicable*)

_____
Print Personal Representative's Name (*if applicable*)

Sworn to before me this _____
day of _____, 20__.

_____
Notary Public

Authorization for Use and disclosure of Protected Health Information Requested by the Provider for Disclosure by Other Providers or Payors[1]

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Print Personal Representative's Name (*if applicable*)

Sworn to before me this _____
day of _____, 20__.

_____
Notary Public

POWER OF ATTORNEY

KNOW ALL MEN BY THESE PRESENT, that I,_____, residing at _____, have made, constitute, and appoint, Lawrence M. Gordon, Attorney At Law, P.C. my attorney in fact to act in my name, place and stead in any way which I could of if I were personally present with respect to signing and endorsing my name to any check or draft received in settlement of my action commenced in the Supreme Court, NASSAU County against defendant(s) _____, giving and granting the said Lawrence M. Gordon, Attorney At Law, P.C. full power and authority to do and perform all and every act and thing whatsoever requisite and necessary to be done in and about the premises, as fully to all intents and purposes as I might or could do if personally present, with full power of substitution and revocation, hereby ratifying and confirming all that said Lawrence M. Gordon, Attorney At Law, P.C. or their substitute, shall lawfully do or cause to be done by virtue thereof.

IN WITNESS WHEREOF, I hereunto set my hand and seal this ____ day of _____, 20___.

_____

STATE OF NEW YORK, COUNTY OF ss.:

On the day of , 20 , before me, the undersigned, a Notary Public in and for said State, personally appeared

personally known to me or proved to me on the basis of satisfactory evidence to be the individual(s) whose name(s) is (are) subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their capacity(ies), and that by his/her/their signature(s) on the instrument, the individual(s), or the person upon behalf of which the individual(s) acted, executed the instrument.

_____
Notary Public

Date:_____

To: Lawrence M. Gordon
Attorney At Law, P.C.
300 Garden City Plaza, Suite 450
Garden City, New York 11530

Gentlemen:

The undersigned hereby agrees to reimburse your firm for any and all out of pocket expenses incurred in connection with the prosecution of my personal injury claim. I will remit these expenses to you on an as and when basis or upon your billing request.

These expenses include, but are not limited to: process serving fees, court filing fees, calendar fees, jury fees, Examination before trial transcripts, medical reports, hospital discharge summaries, case investigation, trial preparation, photographs, telephone expenses, postage and photocopies.

Very truly yours,

_____
[Signature of Client]